

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Rising Health Care Costs

TO THE EDITOR: May I say "right on" to your reprinted 1968 editorial "Rising Health Care Costs" in the April 1982 issue of the journal?¹

As providers of medical care, physicians are caught in the middle of a "Catch 22" situation on the issue of health care costs. Let us hope that in time the public will understand that physicians in general provide the best care they can under prevailing circumstances. They do not promise, as the politicians and bureaucrats do, that such care will be available to everyone at negligible cost.

However, there appears to be a faint ray of hope for physicians in California: the astute Speaker of the California Assembly, Mr. Willie L. Brown, acknowledged recently that, perhaps, the state can't afford "mainstream" care for all its citizens. Now, he and other government officers and officials should acknowledge that it is not the costs of care by physicians alone but also those of all other health care providers, especially hospitals, and the overall inflation in this country, that are responsible for health care cost increases. Should the foregoing ever occur, then as physicians we can spend less time fighting in the political arena and devote more time in the health field for which we are trained and needed.

ARTHUR H. COLEMAN, MD
San Francisco

REFERENCE

1. Watts MSM: Rising health care costs (Medicine in Perspective). West J Med 1982 Apr; 136:367-368

Another Indication for Coronary Bypass

TO THE EDITOR: The April Medical Progress review by Carr, Engler and Ross of the persistent question of prolongation of survival after surgical bypass is a thoughtful and critical assessment of many reports.¹ The editorial comments by Braunwald and Stone² add emphasis and an independent perspective. Both deal with the issues on the basis

of the clinical history and pertinent data obtained by invasive catheterization studies to define pertinent details of anatomical disease and functional impairment in the patient at rest. *Neither deals with the presenting clinical problem of whether further trials of medical treatment or diagnostic studies for possible surgical treatment should be recommended when a symptomatic patient with angina is first seen.*

It is in this context that it seems appropriate to call attention to still another report from the non-invasive exercise testing unit of the Seattle Heart Watch³ which was not cited in Carr and co-workers' excellent review. In the Seattle study retrospective analysis of data collected from 1971 through 1975 on 1,670 patients who did not have operations and 331 patients with coronary heart disease who did have operations identified two important pathophysiologic syndromes that had notably different four-year survival rates in relation to nonrandomized choice of medical or surgical treatment. One was exertional myocardial ischemia characterized by chest pain on exercise testing or ischemic ST depression after such exertion (or both); four-year survival rates of 91 percent to 92 percent indicated no difference in these low-risk patients. The other was designated as left ventricular dysfunction based upon any one or more of three findings: cardiomegaly, exercise duration less than three minutes in stage I (Bruce protocol, requiring 4 to 4.5 mets [metabolic units, multiples of the resting oxygen consumption] of energy expenditure) and peak systolic pressure less than 130 mm of mercury during exercise.

Of all the patients who received surgical treatment, unexpectedly 34 percent had this syndrome and achieved a 94 percent survival by four years. In contrast in the patients who did not have operations and were medically treated, all of whom had at least one artery deemed feasible for grafting by the arteriographers, the survival was only 67 percent ($P < .01$) by fours. *These patients could be screened and classified noninvasively by the*